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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey February 16, 2022 - February 18, 2022.	{D 000}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the safe storage of oxygen tanks on the Assisted Living Unit (AL) and failed to ensure the facility was free of hazards left accessible to 11 residents on the Special Care Unit (SCU). The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 76 residents with a Special Care Unit (SCU) capacity of 19 residents. The facility's census in the SCU was 11 residents and in AL was 22. 1. Review of the facility's oxygen therapy policy dated November 2018 revealed: -Residents requiring supplemental oxygen	D 079		

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therapy may utilize enrichers, concentrators, and small compressed oxygen cylinders based on state regulation.
-The use of long plastic tether lines to the main source of oxygen may not be used based on state regulation.

Review of the facility's Gas Tanks/Compressed Gas Cylinders Guideline for Safe Handling policy dated April 2018 revealed:
-The policy defined the process for the safe handling and use of compressed gas cylinders for all associates, residents and visitors.
-The management team was responsible to check the compressed gas cylinders had no leaks, were used properly, and stored in safe locations.
-Associates were to be trained on the proper handling and use of compressed gases prior to working with them.
-Cylinders were to be provided with chaining, strapping, or stands to prevent tipping exposure.
-Empty cylinders were to be stored separately from full cylinders and labeled as such.
-Cylinders should not be dropped, struck, or permitted to strike each other violently.
-Cylinders were to be stored in a well protected, well ventilated, dry locations at least 20 feet from combustible materials and where the cylinders would not be knocked over or damaged by associates/residents/visitor(s) or where the cylinder could not be tampered with by residents or visitors.
-The number of oxygen cylinders stored in a resident room should be based on resident need as stated in the physician order for oxygen with staff assisting the resident with replacement of empty cylinders as scheduled or needed.
-Oxygen cylinders should be transported in accordance with the manufacturer's instructions

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D 079	Continued From page 2 and service company's direction. Observation of resident room #204 on the AL unit on 02/16/22 at 9:56am revealed: -There were 17 total oxygen tanks sitting on the floor next to and in front of the resident's dresser with a television on top of it; 15 of the 17 tanks were sitting unsecured with no non-tip securement. -The resident sat in front of the dresser in a sitting chair with her rollator/walker in front of her and oxygen tubing draped across the room to reach her from her oxygen concentrator near her bed. -There was a pair of shoes sitting next to three of the unsecured tanks, and another pair of shoes and a blanket on the floor sitting between the resident's walker and the tanks in front of and next to her. -There were 8 short oxygen tanks (approximately 1.5 feet tall); 2 of the 8 tanks were full of oxygen. -There were 8 tall oxygen tanks (approximately 3 feet) sitting on the floor unsecured; 6 of the 8 unsecured tanks were full of oxygen. -There was 1 short oxygen tank sitting next to the resident's feet with oxygen tubing connected laying freely across the floor and across the wheel of her walker that was full of oxygen. -There were 9 of 17 total oxygen tanks sitting on the floor next to and in front of the resident's dresser with a television on top of it unsecured that were full of oxygen. -The resident applied the oxygen tubing to her face when she began to talk due to being short of breath. -The resident was unable to be viewed from the hallway and there was no staff around to supervise the resident using her tanks or ambulating around her room. Observation of resident room #204 on the AL unit	D 079		

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with oxygen tanks in it on 02/16/22 at 11:32am remained unchanged.

Observation of resident room #204 on the AL unit with oxygen tanks in it on 02/16/22 at 5:05pm revealed the unsecured oxygen tanks had been removed from the resident's room except for the small portable oxygen tank which was now in a bag connected to her walker, under the seat, secured with velcro.

Interview with the resident assigned to room #204 on 02/16/22 at 9:56am and 11:32am revealed:
-Her family member usually took care of bringing her full oxygen tanks and taking away the old tanks because the facility did not usually do it for her.
-She had to wear her oxygen all the time due to being short of breath.
-She had long oxygen tubing to try and get around her room without taking the oxygen off.
-Her family member had recently made her oxygen tubing shorter because she sometimes tripped over it.
-She used the small tanks when she left the room or went to the bathroom where her oxygen concentrator tubing would not reach to have portable oxygen.
-She did not have any special portable carrying devices or non-tip storage for any of the unsecured or portable tanks.
-When she needed portable oxygen, she would place the metal tank in the velcro bag under the seat of her walker.
-The tank was sometimes too heavy for her to lift, so staff would help her put the tank in her walker bag.
-Sometimes the tank was so heavy that the velcro bag would release from her walker and fall to the floor dumping the supplies and the oxygen tank

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she was using.

Interview with the lead medication aide (MA) on 02/16/22 at 11:38am revealed:
-She did not realize there were so many unsecured oxygen tanks in the resident's room.
-There was a locked supply cabinet that staff could store oxygen tanks in safely down the hall from the medication room, but residents often stored their oxygen tanks in their room.
-It was her or the Health and Wellness Director's (HWD) responsibility to ensure oxygen tanks were stored properly and safely.
-Tanks were supposed to be stored in a rolling caddy or a non-tip container, but she was not sure why.
-There was no process in place to check oxygen tanks on a regular basis to ensure they were stored safely.
-She tried to check tanks in resident's rooms each shift that she worked but she was unsure if other MAs did the same.
-The resident assigned to room #204 had multiple tanks in her room because the durable medical equipment (DME) company did not remove the empty tanks the last time they brought the resident new tanks.
-She was not sure why there was no non-tip storage to store the tanks in the resident's room.
-It was concerning that the tanks were not stored properly because if it fell over it could be a safety issue; she was not sure what would happen.
-The tanks were too heavy for the resident assigned to room #204 to lift, so staff helped the resident put the tanks in her walker bag, so the resident had access to portable oxygen.
-She had never received any training from the facility regarding safe oxygen tank storage.

Interview with the maintenance staff on 02/16/22

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at 12:14pm revealed:
-Oxygen cylinders were stored in the locked medication room located on the AL unit of the facility.
-Oxygen cylinders were stored in either a stand or storage crate for stabilization and securement of the cylinder.
-The resident assigned to resident room #204 had oxygen cylinders in her room for her use that were stored in a crate rack and stands.
-He was not sure why, but he saw the resident's oxygen supplier pick up a oxygen storage crate and stand rack from the resident's room approximately one month or more ago.
-He had not observed any of the resident's oxygen cylinders being stored in the resident room #204 unsecured without a stand or crate.
-He knew it was important to never store oxygen cylinders on the floor without any securement device for safety reasons because if the cylinder tipped over, it could explode.

Interview with the HWD on 02/16/22 at 11:53am revealed:
-She was not sure if oxygen tanks were supposed to be stored in resident rooms.
-She was not sure who's responsibility it was to ensure oxygen tanks were stored safely.
-There was a supply room with non-tip containers to store oxygen tanks in if needed.
-Oxygen tanks were supposed to always be stored in a non-tip container to prevent them from tipping or causing injury.
-She was not sure what the facility's policy for storing oxygen tanks was.

Second interview with the lead MA on 02/17/22 at 1:06pm revealed:
-She removed the oxygen tanks from resident room #204 last night after she had been educated

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by the facility's leadership on how to properly store oxygen tanks and why it was important.
-There were no non-tip storage containers available last night, so she locked the tanks, unsecured on the floor in the medication room until the next day when she was able to obtain non-tip containers to store them.

Interview with the facility's contracted DME company on 02/18/22 at 3:27pm revealed:
-Oxygen tanks should always be stored in a non-tip cart or stand to prevent them from tipping.
-Portable tanks should always be stored in a special tank bag made specifically for wheelchairs and walkers to ensure they were cushioned and did not fall.
-Oxygen tanks should never be stored unsecured on the floor because they could be a trip hazard or could cause injury if they tipped because they could potentially explode or become projectile if they tipped causing injury to anyone within the vicinity; it was also important to store portable oxygen tanks in a special cushioned bag made specifically for wheelchairs to prevent hazards or injury if it fell.
-The facility was responsible for the safe storage of resident oxygen tanks and could always request non-tip containers or cushion bags from the DME company as needed to prevent injury.

Telephone interview with the facility's contracted primary care provider (PCP) on 02/21/22 at 3:48pm revealed:
-Any excess items in a resident's room would be concerning and a fall hazard.
-It was concerning that the resident assigned to room #204 had 17 oxygen tanks in her room due to the fall hazard, because the resident's long oxygen tubing could get caught up in the tanks, and also because the tanks were not stored in a

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non-tip storage device and could have become explosive if they fell.
-She expected the facility to store oxygen tanks in a safe location and in a separate room from the resident's room, in a non-tip storage device.
-She also expected the facility to routinely check the tanks the resident was using and label them empty or full to ensure the resident did not try to hook her oxygen tubing up to an empty tank in her room.
-The tanks were too heavy for the resident to lift or to sit in her walker bag secured by Velcro for portable oxygen.
-She expected the facility to provide a safe non-tip carry or rolling device to provide portable oxygen to the residents as needed and to ensure the tank did not fall and become explosive.

2. Review of the facility's policy for Resident Personal Care Items for the Special Care Unit (SCU) dated October 2016 revealed:
-The policy served as a guide to proper storage of personal care items.
-Some residents were not always able to recognize how all personal care items or toiletries were to be properly used, to include toothpaste, mouthwash, liquid or bar soap, shampoo, cologne, perfume, body splash, razors, lotion, makeup, shaving cream, nail care items, etc.
-The above items could present a safety risk if there were consumed or used inappropriately.
-Residents moved freely within the SCU, including from resident room to resident room, and it was important that all areas of the community were made as safe as possible, to include bath areas and resident rooms.
-Liquid care items were not to be out and available to residents where they might be mistakenly ingested.
-Large quantities of liquid care products and bars

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of soap were to be stored in a locked cabinet.
-Toothpaste, brushes, combs, lotions, soap, shampoo, cologne, perfume, and other resident items may be placed in a tote bag or plastic storage container and stored on the top shelf of the closet out of view and reach of most residents or locked in a cabinet or drawer that could only be opened with a key.
-All items labeled "Keep out of reach of children" must be stored in a locked drawer or cabinet.

Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 76 residents with a SCU capacity of 19 residents.

The facility's census in the SCU was 11 residents and in Assisted Living (AL) unit was 22.

Review of the current FL-2's of the 11 residents who resided on the SCU unit revealed:
-There were 2 residents assessed with intermittent disorientation.
-There were 5 residents assessed with constant disorientation.
-There were 4 residents who did not have their disorientation status assessed.
-There were 3 residents assessed to have wandering behaviors.
-There were 5 residents assessed as ambulatory, 3 as semi-ambulatory, and 3 that did not have ambulation assessments completed; there were zero residents documented as non-ambulatory.

Interview with a personal care aide (PCA) on 02/16/22 at 9:08am revealed:
-There were 11 residents total on the SCU.
-There were 4 residents in the SCU who required more time and attention that others due to heavy care.

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D 079	Continued From page 9 -There were 3 residents in the SCU who wandered and required increased supervision to keep them from getting into things or hurting themselves. a. Observation of a resident room on the (Special Care Unit (SCU) unit on 02/16/22 at 9:30am revealed: -There was a bottle of hydrocortisone 1% foam spray on the bedside table: there was a warning on the bottle stating the contents were under pressure, for external use only, to avoid contact with eyes and genitals, and if swallowed to get medical help right away and call poison control. -There was a large bottle of lotion in the bathroom on the counter next to the sink; there was a caution label on the bottle stating for external use only. -There was a basket in an unlocked closet with a large bottle of lotion, dish soap, hand soap, body wash, and deodorant. -The lotion had a caution label to use as directed and avoid contact with eyes; the dish soap had a warning label to avoid contact with eyes or ingestion; the deodorant had a warning label to avoid contact with broken skin; the hand soap's warning label stated for external use only, avoid contact with eyes and get medical help immediately. -All products were labeled to keep out of reach of children. Interview with the personal care aide (PCA) on 02/16/22 at 12:11pm revealed: -It was the facility's policy to lock all toiletries on the SCU in the shower room or a locked closet in the resident's room away from residents' reach because the residents could ingest the items or get them in their eyes. -She did not realize there were toiletry items out	D 079		

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in a resident room; that particular resident had been out of the facility after a fall and had been at the hospital and rehabilitation for the last 3-4 weeks.
-She was not sure when the last time the resident's room had been checked, but she assumed the items had been out since the resident left the facility.
-It was concerning that toiletry items were left out because there were several residents who had wandering behaviors in the SCU and they could have gone into that room.

Interview with another PCA on 02/18/22 at 4:10pm revealed:
-She was unaware that there were toiletries accessible to the residents in the SCU but all the residents on SCU had cognition issues and could ingest the items.
-There was one resident in particular that should not be around hazardous liquids because it would be dangerous for her due to her confusion and wandering behaviors.

Interview with the lead medication aide (MA) on 02/16/22 at 11:38am revealed:
-Toiletries on the SCU such as soaps, deodorants, sprays, toothpaste, mouthwash, and lotions were to be kept in the locked shower area or in a locked closet in the resident's rooms.
-There were 4 residents with wandering behaviors in the SCU and many residents who had memory issues and might try to drink the toiletry products.

Interview with the SCU Activity Director on 02/16/22 at 12:18pm revealed:
-She was unaware that there were toiletry items out in one of the resident rooms.
-It was concerning that the items were out

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because the resident had been out of the facility for 2-3 weeks and there were residents on the SCU who could have wandered into the room and had access to the items.
-It was all staff's responsibility to address safety concerns immediately as they recognized them.
-There was no process in place to check the unit for safety on a regular basis.

Interview with the Health and Wellness Director (HWD) on 02/16/22 at 11:53am revealed:
-All toiletry items were supposed to be stored in the locked shower room and not in the resident rooms on the SCU.
-It was a safety issue to have toiletry items out and accessible to residents because the residents could ingest them.
-It was concerning that the toiletry items were out in a resident room because residents could wander into the room and have access to them.
-To her knowledge, there had not been any residents to ingest toiletry items on the SCU.

Interview with a resident's mental health provider on 02/18/22 at 3:50pm revealed:
-She expected toiletries and other hazards to be out of reach of SCU residents for their safety to ensure they did not ingest the chemicals.
-She expected toiletries and other hazards to be removed from the SCU environment unless residents were being directly supervised with the use of those items.

Telephone interview with the facility's contracted PCP on 02/21/22 at 3:48pm revealed:
-She expected hazards such as toiletries to be locked up in the SCU and out of residents' reach.
-It was possible that residents on the SCU would ingest toiletries and it would be harmful to the resident if that happened.

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D 079	Continued From page 12 b. Observation on the Special Care Unit (SCU) on 02/16/22 from 9:08am to 9:50am revealed: -There were several activity stations for residents to use and interact with in the hallways outside resident rooms. -There were two activity stations with small loose or broken items such as an open container of small (approximately 1 inch) screws and a container of washers (approximately 1 inch in diameter) on a tool activity station, and a a jewelry box on a table of a dress up activity station in the hall that had a broken necklace with loose yellow beads about 1 inch in diameter and a nickel. -There were several residents walking the halls and passing the activity stations. Interview with a personal care aide (PCA) on 02/16/22 at 12:11pm revealed: -She started working at the facility in January of 2021 and there had always been activity stations in the hallways that were out all of the time and were not part of the scheduled activities. -She was aware there were small items such as screws and it was concerning because the items could be ingested, but she was not aware that any safety concerns had ever arisen about the items. -She had previously expressed her concerns about the items to the maintenance director but never received any follow-up. -She never reported her concerns to anyone else; she was not sure why. A second interview with the PCA on 02/17/22 at 7:59am revealed: -There should be more than one PCA on the SCU due to the amount of care and supervision some of the residents required due to several residents	D 079		

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BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

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who had wandering behaviors making it difficult to keep them safe.
-The medication aide (MA) would help with resident care and supervision when she was able, but she was often busy administering medications and unavailable to help.
-She was not sure how long the broken necklace with loose beads or nickel had been in the jewelry box activity station.
-No one regularly checked the activity stations to ensure items were intact and safe.
-It was concerning that there were small loose items and sharp objects on activity stations because the residents could swallow those items or hurt themselves.
-She had not reported her concerns recently because nothing was ever done when she expressed her concerns previously to the Administrator and the Maintenance Director.

Interview with another PCA on 02/18/22 at 4:10pm revealed:
-There were at least two residents that routinely liked to use the activity stations in the SCU.
-She was unaware that there were small and broken pieces at the stations but all the residents in the SCU had cognition issues and could put the items in their mouth and choke on them.

Interview with a MA on 02/16/22 at 4:42pm revealed:
-Items of concern on the tool activity stations should have been secured.
-She was never instructed to secure or inspect on the activity stations.

Interview with the lead MA on 02/16/22 at 11:38am revealed:
-She was not aware that there were small items such as screws and washers on the activity

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stations that were not stored safely.
-There were 4 residents that had wandering behaviors in the SCU and many residents who had memory issues/confusion who might try to swallow small pieces on the activity stations.
-The activity stations were always out and available to residents to use.
-She was concerned that confused residents could swallow the screws.

Interview with the SCU Activity Director on 02/16/22 at 12:18pm revealed:
-There had been unsupervised activity stations in the hallways since she started in February 2021.
-There were items on the tool activity station that could harm the residents, but she never reported them because she did not usually see many residents using the activity stations.
-There were multiple residents who had wandering behaviors on the SCU and could get into the small items and possibly ingest them.
-It was all staff's responsibility to address safety items immediately as they recognized them.
-There was no process in place to check activity stations for safety and intact items.
-To her knowledge, there had not been any occasions where residents had ingested or injured themselves with items on the activity stations.
-She had never received any instructions to supervise residents using the activity stations or lock the items up when not in use.

Interview with the Health and Wellness Director (HWD) on 02/16/22 at 11:53am revealed:
-She was unaware that there were potentially dangerous items on the activity stations in the SCU that were not stored safely.
-It was concerning because residents in the SCU could ingest the screws.

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D 079	Continued From page 15 Interview with the HWD on 02/17/22 at 7:45am and 8:59am revealed: -The broken necklace beads in the jewelry activity station resembled jellybeans and could be ingested by residents. -She was unsure how long the beads in the jewelry station had been loose. -Residents could ingest the beads if they put them in their mouth. -Safety issues and hazards were to be checked every shift during communication walking hand-off rounds from shift to shift. Interview with the Administrator on 02/18/22 at 9:05am revealed: -Staff had never reported concerns of dangerous items. -The HWD was frequently in the SCU and had also never brought any concerns to her. Telephone interview with the facility's contracted primary care provider (PCP) on 02/21/22 at 3:48pm revealed: -Residents who resided in the SCU had dementia and would often pick up small items and put them in their mouths or eat them thinking the items were candy. -She expected all hazardous items such as small screws, washers, and beads to be out of residents' reach, stored safely. -She expected the SCU to have an inventory and safety check process in place to know how many of each small items were present and a routine way to check and ensure all items were accounted for to ensure all items remained intact to ensure no residents accidentally got a hold of the items. -It was important for staff to have SCU specific training with follow-up education to staff could	D 079		

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D 079	Continued From page 16 safely respond is issues such as safety, hazards, reaction to behaviors, and therapeutic responses to residents with dementia. Interview with the facility's contracted mental health provider on 02/18/22 at 2:50pm revealed she expected any small items that could be swallowed to be removed from the SCU environment unless residents were being directly supervised with the use of those items because they could swallow the items and hurt themselves. _____ The facility failed to ensure oxygen tanks were stored securely in non-tip containers in a resident's room creating a potential trip hazard or for an unsecured tank to fall and/or be knocked over becoming projectile or explosive causing injury to those in the vicinity of the Assisted Living Unit. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 04, 2022.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide supervision to 1 of 5 sampled residents (#3) who had a history of falls prior to admission and two falls within a one-week period of admission.

The findings are:

Review of the facility's falls policy revealed:
-Residents were to receive a fall risk assessment upon admission and as needed thereafter.
-Residents were to receive a post-fall evaluation after each fall indicating any interventions implemented and documented in the resident's record.
-The resident was to receive an initial service plan that would be reviewed and updated as needed thereafter.
-Falls were to be documented and tracked noting injuries.

Review of Resident #3's current FL-2 dated 01/10/22 revealed:
-Diagnoses included Alzheimer's Disease, dementia, and major depression.
-The resident was constantly disoriented, ambulatory, and had wandering behaviors.
-The resident required total assistance with personal care.
-Her level of care was the Special Care Unit (SCU).

Review of Resident #3's addendum to FL-2 dated 01/10/22 revealed:

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D 270	Continued From page 18 -The resident had behavioral problems with dementia. -She was not able to follow instructions. Review of Resident #3's Resident Register dated 01/27/22 revealed: -Her admission date was not documented. -The resident had significant memory loss and required direction. Review of Resident #3's facility progress notes revealed her admission date was 02/07/22. Review of Resident #3's current assessment and care plan dated 02/15/22 revealed: -The resident had a heightened risk for falling and had a history of falls. -The resident had wandering behaviors, required redirection, verbal prompts, and escorting due to memory impairments. -The resident had sleep/wake disturbances. -The resident was not always oriented to person, place, or time, and had difficulty communicating needs and preferences. -The resident demonstrated anxious, disruptive, and obsessive behaviors requiring additional attention. -The resident would attempt to exit the building without needed supervision and pace the floor constantly. Review of Resident #3's assessment and care plan addendum dated 02/07/22 revealed: -The resident had wandering behaviors. -The resident required total dependence with dining, toileting, ambulation, bathing, dressing, hygiene, grooming, and transferring. Review of Resident #3's fall risk evaluation dated 02/07/22 revealed:	D 270		

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-The resident had shoes that could cause a fall, had an unsteady gait, had experienced falls with injuries in the last 12-months, appeared unsteady when ambulating, had a history of cognitive decline, and was known to pace the floor.
-The resident was deemed a level 3 of 3 high fall risk.
-There was no documented plan to provide the resident with increased supervision in regards to her fall risk.

Review of Resident #3's Incident/Accident (I/A) Report dated 02/11/22 revealed:
-The resident experienced an unwitnessed fall in the common area in which she hit the side of her head and right hand.
-The resident had a scrape, bruising, skin tear, and a head injury.
-The resident was transported to the emergency department (ED) via ambulance.

Review of Resident #3's ED provider note dated 02/11/22 revealed:
-The resident presented to the ED after an unwitnessed fall with a laceration to the right side of her head, right thumb, and chin.
-The resident received lab work and imaging studies (commonly done to rule out internal injury or underlying medical issues that may have contributed to the fall).
-The lacerations were closed with Dermabond (skin glue) after being cleaned.
-The resident was discharged back to the facility with strict instructions to return and follow-up as needed.

Review of Resident #3's post-fall evaluation form dated 02/12/22 revealed:
-The resident was confused and fell by the door of the activity room on 02/11/22.

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-Factors that contributed to the fall were related to compliance with safety issues but were not clarified.
-Clutter and furniture were moved to verify safe walkways.
-There was no documentation of any other interventions or increased supervision for the resident.

Review of Resident #3's I/A Report dated 02/13/22 revealed:
-The resident had a fall in the hallway at 10:00am while walking at a fast speed.
-The resident had injuries to her eye, shoulder, and head that included scrapes, skin tears, and redness.
-The resident was transported to the ED via ambulance.

Review of Resident #3's ED provider note dated 02/13/22 revealed:
-The resident presented to the ED after a witnessed fall with bruising to her face and an abrasion to the left side of her head and shoulder.
-The resident had a bruise on her forehead down to her eye and on her cheek, had an abrasion to her forehead, and was difficult to assess the resident due to dementia.
-The resident received imaging studies and was discharged back to the facility.

Review of Resident #3's post-fall evaluation form dated 02/13/22 revealed:
-The resident was trying to "go home" when she fell that day (02/13/22).
-Risk factors that contributed to the fall included the resident was walking at a fast pace.
-Interventions included having a family member bring in a wheelchair and walker from home.
-There was no documentation of any other

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D 270	Continued From page 21 interventions or increased supervision. Review of Resident #3's facility progress notes revealed: -On 02/08/22, the resident required a two person assist to complete morning activities of daily living care. -On 02/08/22, the resident required total care to be assisted to eat. -On 02/13/22, the resident fell outside of her bedroom while "running throughout the facility". -On 02/14/22, the resident was noted to have bruising to her face and hands, did not eat breakfast, and was tried to get out of her wheelchair and walk around the common area. Review of Resident #3's record revealed: -There was no documentation of any other fall prevention interventions or increased supervision for the resident. -There was no documentation the resident's primary care provider (PCP) had been made aware of any of the resident's falls. Observation of Resident #3 on 02/16/22 at 9:08am revealed: -She was seated in a wheelchair at a table in the activity room. -She was mumbling words that were unintelligible. -The left side of her face was bruised from the top of the forehead to the bottom of her chin with multiple colors of healing to include red, purple, green, and blue hues to the skin. -Her hands had redness and bruising bilaterally. -She had a small laceration to her chin and her thumb. Observation of Resident #3 in the SCU on 02/17/22 from 7:15am to 7:59am revealed:	D 270		

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D 270	Continued From page 22 -At 7:15am, she was sitting in the activity room in a wheelchair unsupervised. -At 7:40am, she got up and exited her wheelchair and began walking the halls with a very unsteady gait and limp. -At 7:45am, the Health and Wellness Director (HWD) realized the resident was up and walking and began escorting her back to her wheelchair in the activity room. -At 7:45am the personal care aide (PCA) came out of another resident's room and stated, "How did she get out of her wheelchair?", then took over escorting Resident #3 back to her wheelchair at the table in the activity room, leaving her there unsupervised to continue to provide care to other residents. -At 7:49am, the resident attempted to stand and exit her wheelchair again. -The resident remained unsupervised until 7:57am when the medication aide (MA) entered the activity room to administer medications to a resident. Observation of Resident #3 on 02/17/22 from 8:10am-8:23am revealed: -She was sitting in her wheelchair and unsupervised by any facility staff. -She stood up and attempted to exit her wheelchair 3 times while unsupervised. Telephone interview with Resident #3's family member on 02/17/22 at 11:17am revealed: -He had been Resident #3's primary caregiver for the last five years but recently had the resident admitted to the Special Care Unit (SCU). -Resident #3 had fallen twice since her admission to the SCU on 02/07/22 which was concerning because she hit her head and had to go to the ED for both falls. -She had a history of falling at home as well,	D 270		

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which was discussed with the facility prior to admission, but she had never experienced serious injury needing medical attention because she was used to holding on to the furniture and her surroundings; she did not have much to hold on to at the facility.
-Staff were unable to watch her closely because there was not enough SCU staff available to supervise the resident according to her needs because she would required constant supervision to prevent her falls.
-There had been no specific fall interventions or increased supervision put in place for Resident #3 to his knowledge.
-He visited the resident three times per day to stay visible to try to ensure the resident received the care she needed.
-The facility was still getting to know the resident.

Interview with Resident #3's family member on 02/18/22 at 12:07pm revealed:
-The facility had never suggested any fall prevention interventions, increased supervision, or requested a sitter for Resident #3.
-He had previously suggested the facility have the resident wear non-slip shoes and brought a wheelchair and walker to the facility for the resident's use, but it was unlikely the resident would be able to use it without assistance due to her cognitive ability.

Interview with a PCA on 02/17/22 at 7:59am revealed:
-Resident #3 and another resident were known to have frequent wandering behaviors.
-The SCU averaged 1-2 falls per week due to not being able to supervise all 11 residents on the SCU at one time.
-She was not present when Resident #3 fell, but when she returned to work, she was shocked at

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the bruising on the resident's face.
-She came in at 7:00am and it was her responsibility to get all 11 residents in the SCU up and dressed then escort them to the dining room for breakfast at 8:30am.
-There should be more than one PCA on the SCU due to the amount of care and supervision some of the residents required.
-There were several residents on the SCU who had wandering behaviors and frequently fell making it difficult to keep them safe.
-The medication aide would help with resident care and supervision when she was able, but she was often busy administering medications and unavailable to help.
-There was no policy or procedure in place for supervision of residents and no documentation of routine or organized safety or supervision checks.
-It was all of the SCU staff's responsibility to supervise residents and she was expected to do her best to keep her eyes on all the residents as best as possible.
-She had expressed her concerns about not being able to supervise residents and keep them safe about 4-5 months after working at the facility once she really got to know the residents to the Health and Wellness Director (HWD) and the Administrator and several times thereafter; the last time being about 2 months ago.
-She had not reported her concerns recently because nothing was ever done when she expressed her concerns previously.

Interview with another PCA on 02/18/22 at 4:10pm revealed:
-Resident #3 was anxious in her new environment at the facility since her admission.
-She was working when Resident #3 had an unwitnessed fall on 02/11/22.
-She realized Resident #3 was "gone" and when

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looking around the SCU for her, the resident was walking around the unit looking for her family member and she found the resident on the floor.
-She tried to supervise Resident #3 as much as possible because she knew the resident could be fast with an unsteady gait and required a lot of attention and a "close eye".
-She had never been specifically instructed to provide Resident #3 with increased supervision, only to keep a close eye on her.
-If provided to a resident, increased supervision was not documented anywhere.
-The only intervention she was aware of that had been implemented for Resident #3's falls was the use of a wheelchair; she could not recall when that took place.

Interview with a medication aide (MA) on 02/18/22 at 4:23pm revealed:
-Resident #3 had wandering behaviors and liked to try and run from staff.
-She had never witnessed any of Resident #3's falls and had never been told whether the resident had a history of falls upon her admission.
-She had never been instructed to provide Resident #3 with increased supervision but knew the resident had fallen recently at the facility.
-She tried to keep a close eye on Resident #3 because she did not want the resident to fall again.
-To her knowledge, there were no orders for any additional fall prevention interventions or increased supervision for the resident.
-There was no process in place to document supervision/safety checks at the facility.

Interview with the Health and Wellness Director (HWD) on 02/16/22 at 11:53am revealed:
-Resident #3 had an abnormal gait, tried to run, and had two falls since her admission on

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D 270	Continued From page 26 02/07/22. -One of Resident #3's falls was unwitnessed, and one fall was witnessed. Interview with the HWD on 02/17/22 at 8:59am revealed: -Resident #3 was a high fall risk and had experienced two falls back to back because she would not sit still and did not understand how to use her walker. -It was her responsibility to fill out the fall risk assessment forms and communicate any interventions or increased supervision to staff which would then be passed on to other staff members during walking rounds and communication hand-off. -Supervision checks were not documented and there was no increased supervision in place for Resident #3 with no reason why. -Supervision/safety checks were expected to be performed on the SCU residents every two hours. -There was no documentation of supervision or safety checks. -Staff knew if there were concerning residents who had additional needs for increased supervision by reading the shift to shift hand off communication reports and by walking hand-off communication rounds from staff to staff. -Increased supervision should be put in place for residents who experienced concerning behaviors, change in condition, or falls as needed on a situational basis by the HWD or the Administrator. -The frequency of increased supervision would vary depending on the resident but was usually every hour. -Staff had never reported concerns to her about being unable to supervise residents in the SCU and keep them safe. Interview with the HWD and Administrator on	D 270		

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02/18/22 at 9:05am revealed:
-Residents were to have a post fall evaluation after each fall to include resident specific interventions such as increased supervision if appropriate for the situation.
-Resident #3 had a sitter prior to her admission to the facility at home, but the family member did not prefer to employ the sitter for the resident while she was a resident at the facility.
-It would have been the HWD or Administrator's responsibility to implement fall prevention interventions or increased supervision, but they could not recall what had been implemented for Resident #3 after each of her falls at that time.

Interview with the Administrator on 02/18/22 at 9:05am revealed:
-Staff had never reported concerns of being unable to supervise residents on the SCU due to the residents' level of care.
-If she had been aware of staff concerns relating to being unable to supervise residents on the SCU, it would be an important discussion to entertain due to concerns for resident safety.
-The HWD was frequently in the SCU and had also never brought any concerns to her.

Interview with the Administrator on 02/18/22 at 5:32pm revealed:
-She was unaware that Resident #3's PCP had not been notified of her falls.
-She expected the resident's PCP to be notified by the MA after each fall so that orders for interventions could be provided.
-It was an oversight on her part that she did not ensure the resident's PCP had been notified.

Interview with Resident #3's PCP's nurse on 02/18/22 at 12:33pm revealed:
-The resident was last seen by the PCP that day

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(02/18/22), was previously seen on 01/05/22 prior to her admission to the facility, and was just made aware of the resident's falls at the facility that day (02/18/22).
-Resident #3 had wandering behaviors and the PCP was not notified of any of the resident's falls at the facility; the PCP expected to be notified of the resident's falls after each fall.
-If the PCP had been notified of the resident's falls, she would have requested to see the resident for a follow-up appointment or directed the facility to have her seen by an after-hours provider to provide orders and request interventions to prevent further falls, and to provide follow-up medical interventions, monitoring, and imaging as needed after being assessed.
-If the PCP had known about the falls, she would have approved orders for constant supervision and any fall prevention interventions the facility could have accommodated.
-The resident was not a candidate to for a wheelchair, walker, physical therapy, or rehabilitation due to her dementia and required constant supervision and non-slip shoes to prevent further falls.
-The PCP had not provided an order for a wheelchair or walker and would be concerned if the resident was using one due to the resident's cognitive abilities and her inability to use it independently.
-It was concerning that there were no interventions or increased supervision in place for the resident because the injuries the PCP had assessed that day, 02/18/22, were alarming.
-It was important for the resident's safety to have increased supervision and fall prevention interventions in place to prevent future falls and injuries.
-Because she was not aware of the resident's fall

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D 270	Continued From page 29 until that day, it was difficult for her to say what she would have specifically wanted to implement to prevent further falls until she assessed the resident and discussed what orders to put in place with the facility. _____ The facility failed to provide supervision to 1 of 5 sampled residents (#3) according to the resident's assessed needs and symptoms which resulted in two falls within one week of the resident's admission causing injuries that required her to be assessed in the emergency department (ED) in which she did not receive any intervention of increased supervision after her falls. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/18/22. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 04, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to notify the primary care provider for 2 of 5 sampled residents (#5, #3) related to rectal bleeding (#5) and two falls within one week of	D 273		

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admission (#3).

The findings are:

1. Review of Resident #5's current FL-2 dated 10/13/21 revealed diagnoses included type 2 diabetes, rheumatoid arthritis, dementia without behavioral disturbances, disorder of cornea and seasonal allergies.

Review of Resident #5's progress notes revealed:
-On 01/05/22, there was an entry when cleaning the resident, blood was noticed in the resident's incontinent brief; reported to the Health and Wellness Director (HWD).
-On 01/07/22, there was an entry the resident still had anal bleeding.
-On 01/07/22, there was an entry the resident was bleeding from hemorrhoids, the primary care provider (PCP) was faxed.

Review of a faxed PCP's Order Sheet for Resident #5 dated 01/06/22 revealed:
-There was an entry the resident's hemorrhoids appeared to be bleeding, please advise.
-There was no provider signature.

Review of an emergency department (ED) visit for Resident #5 dated 01/11/22 revealed:
-The resident presented to the ED with rectal bleeding with noticed blood for the last couple of mornings, bright red blood at times and questionable prolapse.
-The resident was having abdominal pain and cramping.
-In the physical exam section it was documented the resident was having some mild abdominal discomfort with no focal area of pain.
-A rectal exam showed a mild rectal prolapse.
-A referral was completed for gastroenterology for

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follow up for a pancreatic mass.
-The resident was not prescribed any medications and discharged back to the facility.

Interview with the HWD on 02/18/22 at 3:35pm revealed:
-Resident #5 was having diarrhea in December 2021.
-She remembered Resident #5 was prescribed a medication by her PCP for the diarrhea and then later developed hemorrhoids.
-She did not document a note in Resident #5's record concerning the development of the resident's hemorrhoids or contact with the provider but thought a note in the resident's progress note would have been needed.
-Resident #5 was evaluated by her PCP in January 2022 and a gastrointestinal referral was ordered.
-She could not provide an answer why there was no documentation in Resident #5's record confirming the resident's PCP was aware of the occurrences of rectal bleeding from 01/05/22 until 01/11/22.
-She would review the resident's record and provide additional documentation if found concerning follow-up with the PCP regarding the resident's rectal bleeding.

At the time of exit on 02/18/22 at 7:00pm, no additional information was provided for notification to Resident #5's PCP regarding rectal bleeding from 01/05/22 - 01/10/22.

Telephone interview with Resident #5's PCP on 02/21/22 at 3:44pm revealed:
-On Friday, 01/07/22, a fax was received at 10:00pm regarding Resident #5 having rectal bleeding, however, a provider would not have responded at 10:00pm because the faxed

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message was sent to the resident's record and there would not have been a response back until the following Monday.
-The fax dated 01/07/22 for Resident #5 was sent to her and at that time, she was covering as a floating provider with the facility's provider office on 01/07/22.
-She was unsure how the facility received her name; she was not providing care to any residents in the facility at that time and would not have received the message until accessing the resident's record.
-At that time (01/07/22) she had never seen the resident and would not have known who the resident was.
-There was an entry on the resident's received fax dated 01/07/22 from the resident's provider's office that the facility was messaged back advising the provider was not scheduled to visit the facility due to the facility not being listed on the provider's schedule for the upcoming week.
-The fax for Resident #5's bleeding on 01/07/22 stayed in the resident record until the resident's record was checked by the provider so the facility would not have received a response back.
-If there was no response back by Saturday, 01/08/22, follow up should have been completed by facility staff to inform no response was received from the fax regarding the resident's bleeding in order to decide what next step should have been taken.
-Resident #5's PCP's office had a 24 hour "tele-medic" messenger service, if used by staff, the facility would have received a response back from a provider.
-Resident #5 was evaluated by another provider on 01/13/22 and prescribed a "cream" (medication) with notation in the visit note the resident had a rectal prolapse and not hemorrhoids.

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-The level of concern regarding rectal bleeding would vary from a very simple concern to a very concerning incident of severity with risks of the resident becoming hypovolemic, needing a blood transfusion or life threatening concerns which would have been dependent on the amount of bleeding the resident was having.
-If Resident #5 started bleeding on 01/06/22 and when staff reached out to the resident's PCP and did not receive a response back then staff should have followed up with the PCP's office regarding the resident's bleeding.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Interview with the Administrator on 02/18/22 at 4:03pm revealed she expected for Resident #5's PCP to be notified by facility staff without delay regarding the resident's rectal bleeding.
2. Review of the facility's falls policy revealed:
-Residents were to receive a fall risk assessment upon admission and as needed thereafter.
-Residents were to receive a post-fall evaluation after each fall indicating any interventions implemented and documented in the resident's record.
-The resident's primary care provider (PCP) was to be notified of the resident's fall.

Review of Resident #3's current FL-2 dated 01/10/22 revealed:
-Diagnoses included Alzheimer's Disease, dementia, and major depression.
-The resident was constantly disoriented, ambulatory, and had wandering behaviors.
-The resident required total assistance with personal care.
-Her level of care was the Special Care Unit

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D 273	Continued From page 34 (SCU). Review of Resident #3's facility progress notes revealed her admission date was 02/07/22. Review of Resident #3's current assessment and care plan dated 02/15/22 revealed: -The resident had a heightened risk for falling and had a history of falls. -The resident had wandering behaviors, required redirection, verbal prompts, and escorting due to memory impairments. -The resident had sleep/wake disturbances. Review of Resident #3's fall risk evaluation dated 02/07/22 revealed: -The resident had shoes that could cause a fall, had an unsteady gait, had experienced falls with injuries in the last 12-months, appeared unsteady when ambulating, had a history of cognitive decline, and was known to pace the floor. -The resident was deemed a level 3 of 3 high fall risk. Review of Resident #3's Incident/Accident (I/A) Report dated 02/11/22 revealed: -The resident experienced an unwitnessed fall in the common area in which she hit the side of her head and right hand. -The resident had a scrape, bruising, skin tear, and a head injury. -The resident was transported to the emergency department (ED) via ambulance. -There was no documentation that the resident's primary care provider (PCP) was notified. Review of Resident #3's ED provider note dated 02/11/22 revealed: -The resident presented to the ED after an unwitnessed fall with a laceration to the right side	D 273		

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of her head, right thumb, and chin.
-The resident received lab work and imaging studies (commonly done to rule out internal injury or underlying medical issues that may have contributed to the fall).
-The lacerations were closed with Dermabond (skin glue) after being cleaned.
-The resident was discharged back to the facility with strict instructions to return and follow-up as needed.

Review of Resident #3's post-fall evaluation form dated 02/12/22 revealed:
-The resident was confused and fell by the door of the activity room on 02/11/22.
-Factors that contributed to the fall were related to compliance with safety issues but were not clarified.
-Clutter and furniture were moved to verify safe walkways.
-There was no documentation of any other interventions or increased supervision for the resident.

Review of Resident #3's I/A Report dated 02/13/22 revealed:
-The resident had a fall in the hallway at 10:00am while walking at a fast speed.
-The resident had injuries to her eye, shoulder, and head that included scrapes, skin tears, and redness.
-The resident was transported to the ED via ambulance.
-There was no documentation that the resident's primary care provider (PCP) was notified.

Review of Resident #3's ED provider note dated 02/13/22 revealed:
-The resident presented to the ED after a witnessed fall with bruising to her face and an

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abrasion to the left side of her head and shoulder.
-The resident had a bruise on her forehead down to her eye and on her cheek, had an abrasion to her forehead, and was difficult to assess the resident due to dementia.
-The resident received imaging studies, was medically cleared, and was discharged back to the facility.

Review of Resident #3's post-fall evaluation form dated 02/13/22 revealed:
-The resident was trying to "go home" when she fell that day (02/13/22).
-Risk factors that contributed to the fall included the resident was walking at a fast pace.
-Interventions included having a family member bring in a wheelchair and walker from home.
-There was no documentation of any other interventions or increased supervision.

Review of Resident #3's record revealed there was no documentation the resident's PCP had been made aware of any of the resident's falls.

Telephone interview with Resident #3's family member on 02/17/22 at 11:17am revealed:
-He had been Resident #3's primary caregiver for the last five years but recently had the resident admitted to the Special Care Unit (SCU).
-Resident #3 had fallen twice since her admission to the SCU on 02/07/22 which was concerning because she hit her head and had to go to the ED for both falls.
-He was unsure if the resident's PCP had been made aware of her falls at the facility.

Interview with a personal care aide (PCA) on 02/17/22 at 7:59am revealed:
-If a resident fell, she was instructed to get help from a medication aide (MA) and assist them as

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needed in responding to the incident.
-It was the MAs responsibility to fill out an I/A Report regardless of injury but she was unsure who's responsibility it was to notify the resident's PCP.
-The I/A Report was then reviewed by the Health and Wellness Director (HWD).

Interview with a second PCA on 02/18/22 at 4:10pm revealed that when a resident fell, it was her responsibility to notify and get help from an MA.

Interview with an MA on 02/18/22 at 4:23pm revealed:
-When a resident fell, it was her responsibility to respond and provide first aid, call an ambulance if necessary, and report the fall to management by turning in an I/A Report to them.
-She was unsure who's responsibility it was to notify a resident's PCP of the fall, but thought the HWD did once she was made aware of the fall.

Interview with the HWD on 02/17/232 at 8:59am revealed:
-When a resident fell, the resident would be sent to the hospital by her or the MA if they had any visible injures after being assessed and provided first aid.
-She thought Resident #3's PCP had been made aware of the resident's falls by her or the MA, but she could not recall for sure.

Interview with the Administrator on 02/18/22 at 5:32pm revealed:
-She was unaware that Resident #3's PCP had not been notified of her falls.
-She expected the resident's PCP to be notified by the MA after each fall so that orders for interventions could be provided.

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D 273	Continued From page 38 -It was an oversight on her part that she did not ensure the resident's PCP had been notified. Interview with Resident #3's PCP's nurse on 02/18/22 at 12:33pm revealed: -The resident was last seen by the PCP that day (02/18/22), was previously seen on 01/05/22 prior to her admission to the facility, and was just made aware of the resident's falls at the facility that day (02/18/22). -Resident #3 had wandering behaviors and the PCP was not notified of any of the resident's falls at the facility; the PCP expected to be notified of the resident's falls after each fall. -If the PCP had been notified of the resident's falls, she would have requested to see the resident for a follow-up appointment or directed the facility to have her seen by an after-hours provider to provide orders and request interventions to prevent further falls, and to provide follow-up medical interventions, monitoring, and imaging as needed after being assessed. -If the PCP had known about the falls, she would have approved orders for constant supervision, a fall mat, fall alarm, and concave mattress. -It was concerning that there were no interventions or increased supervision in place for the resident because the injuries the PCP had assessed that day, 02/18/22, were alarming. -It was important for the resident's safety to have increased supervision and fall prevention interventions in place to prevent future falls and injuries. -Because she was not aware of the resident's fall until that day, she would have to discuss what orders to put in place with the facility. _____ The facility failed to ensure Resident #5's primary care provider was notified related to the resident	D 273		

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D 273	Continued From page 39 having documented rectal bleeding 6 days prior to being evaluated in an emergency department for a partial rectal prolapse and to ensure that Resident #3's primary care provider was notified of two falls in a one week period after her admission on 02/07/22 in which she was treated for injures for both falls at the emergency department for lacerations, abrasions, and bruising. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G S 131D-34 on 02/18/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 04, 2022.	D 273		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur.	{D 276}		

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{D 276}	Continued From page 40 THIS IS A TYPE A2 VIOLATION Based on interviews, and record reviews, the facility failed to ensure implementation of physician's orders for 2 of 5 sampled residents (#4, #1) regarding orders for an x-ray and labs (#4) and an order for vitals signs and oxygen saturations each shift with parameters (#1). The findings are: 1.Review of Resident #4's current FL-2 dated 02/10/22 revealed: -Diagnoses included dementia, hypertension, peripheral vascular disease, osteoarthritis, and COVID-19. -There was no documented assessment information. Review of Resident #4's hospital course record dated 02/08/22 revealed the resident tested positive for COVID-19 with upper respiratory symptoms on 01/23/22. Review of Resident #4's primary care provider's (PCP) visit orders dated 01/25/22 revealed there was an order for a 2-view chest x-ray, complete blood count (CBC), and complete metabolic panel (CMP). (CBC and CMP are labs that can help evaluate a resident's medical status.) Review of Resident #4's mental health provider's orders dated 01/27/22 revealed an order to obtain a urine analysis and culture stain (UA/CS) (commonly used to evaluate whether the resident had a urinary tract infection). Review of Resident #4's record revealed there was no documentation that the resident's chest x-ray, CBC, CMP, or UA/CS had been completed.	{D 276}		

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{D 276}	Continued From page 41 Review of Resident #4's hospital discharge summary dated 02/04/22-02/08/22 revealed the resident had been hospitalized with diagnoses of acute metabolic encephalopathy, pneumonia due to COVID-19 virus, advanced dementia with behavioral disturbance, and transient alteration of awareness. Interview with the lead medication aide (MA) on 02/17/22 at 9:40am revealed: -When an order for labs or x-rays was made by a resident's PCP, the PCP would fax the order to the third-party provider who would come to the facility to complete the order. -There was no facility process in place to follow up and ensure orders were implemented and completed. -It was concerning that there was no audit process in place because orders could get missed. Interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am revealed: -Any orders that were not related to medications were not entered into the facility's computer system. -When a provider requested an order for tasks and procedures such as labs or x-rays, the provider was supposed to fax the order to the third-party provider who would come to the facility to complete the order. -It was her or the lead medication aide's (MA) responsibility to ensure orders had been implemented within one business day. -The facility did not automatically get results from labs or x-rays and she would have to call the third-party provider or primary care provider (PCP) to have the results sent over. -She was not aware of any process in place for	{D 276}		

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{D 276}	Continued From page 42	{D 276}		

record audits to ensure orders had not been missed.
-She was not sure why Resident #2's chest x-ray and labs were not in his record or if they had been completed.

Interview with the Administrator on 02/18/22 at 5:32pm revealed:
-She was not aware that Resident #4's orders for an x-ray and labs had not been completed.
-She expected orders for things such as x-ray and labs to be implemented and followed up on by the facility within 1-2 days by anyone on the clinical team (the lead medication aide (MA), the HWD, or the Administrator) at the facility.
-It was important that orders were implemented and carried out to ensure residents received the care they needed and so the facility could report the results to the PCP for further evaluation.

Interview with Resident #4's PCP on 02/18/22 at 4:52pm and 02/22/22 at 3:48pm revealed:
-She assessed Resident #4 via a virtual visit at the facility on 01/25/22 due to him testing positive for COVID-19 on 01/23/22.
-Even though she was at the facility, the facility did not allow her to see the resident face to face due to him being on contact precautions COVID-19, which made it difficult to assess him.
-If she had been able to assess the resident face to face, she may have had additional orders and it might have made a difference in his outcome.
-Because she was unable to listen to his heart and lungs, she ordered a chest x-ray, CBC, and CMP to evaluate his well-being further.
-When she wrote the order for the chest x-ray, CBC, and CMP, the orders were faxed to the third party provider by her office, but she expected the facility to follow-up and ensure the orders had been completed within 3-4 days at the most.

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-She expected the orders to be carried out in a timely manner to prevent further deterioration of the resident's condition and the facility had not made her aware that the resident subsequently deteriorated with a hospitalization and diagnoses of metabolic encephalopathy and pneumonia due to COVID-19.
-She expected to be made aware when orders had not been carried out or when a resident's condition changed immediately.

Interview with Resident #4's mental health provider on 02/18/22 at 2:50pm revealed:
-The resident had a history of combative behaviors, particularly toward staff at the facility.
-The facility notified her the resident tested positive for COVID-19 on 01/25/22.
-The resident was triaged on 01/27/22 after the facility reported the resident was having combative behaviors throwing shoes and any objects he saw in the hallway.
-A UA/CS was ordered on 01/27/22 to rule out whether the resident was suffering from a urinary tract infection.
-She was not aware the facility sent the resident to the ED on 01/27/22 for continued behaviors.
-The facility subsequently continued to report concerning behaviors for the resident, but when she looked for the lab and chest x-ray results the resident's PCP had ordered on 01/25/22, they had not been done.
-She expected the facility to implement orders for things such as labs and x-rays within 1-2 business days and follow up as needed to ensure they were completed.
-She instructed the facility to send the resident to hospital on 02/04/22 to be medically cleared because she could not rule out his behaviors were not due to an underlying medical condition before she could evaluate his mental health and

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adjust his medications.
-If the labs and x-ray had been carried out as expected and ordered, the resident's hospitalization might have been prevented.
-It was concerning that the facility had not ensured the labs and x-rays had been completed on 01/25/22 because they were ordered to evaluate and treat the resident for a long-term positive outcome and to help keep him safe.

Refer to the interview with the Administrator on 02/18/22 at 5:32pm.

2. Review of Resident #1's current FL-2 dated 10/08/21 revealed diagnoses included unspecified atrial fibrillation, unspecified congestive heart failure, type 2 diabetes, restless leg syndrome, pulmonary hypertension, pacemaker, and oxygen dependent.

Review of Resident #1's subsequent medication orders on a physician fax/order sheet revealed there was an order dated 12/03/21 to monitor vital signs every shift and notify the provider of a temperature greater than 100, pulse oxygen saturation less than 90%, and heart rate greater than 115.

Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to check oxygen saturations every shift and as needed three times a day for shortness of breath with a scheduled time at 8:00am, 2:00pm and 8:00pm.
-There was documentation the resident's oxygen saturations were obtained from 01/01/22 - 01/31/22 with an exception of an "x" with no documented results on 01/03/22 at 8:00pm.
-There was documentation the resident's oxygen

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saturations were 87% at 8:00am and 88% at 2:00pm on 01/01/22, 82% at 8:00am on 01/02/22, and 87% at 8:00am on 01/15/22 for a total of 4 times the resident's oxygen saturations were documented less than 90%.
-There was not an entry to document the resident's vital signs every shift and notify the provider of a temperature greater than 100, pulse oxygen saturation less that 90% and heart rate greater than 115.

Review of Resident #1's February 2022 eMAR revealed:
-There was an entry to check oxygen saturations every shift and as needed three times a day for shortness of breath with a scheduled time at 8:00am, 2:00pm and 8:00pm.
-There was documentation the resident's oxygen saturations were obtained with readings greater than 90% from 02/01/22 - 02/16/22 at 8:00am.
-There was not an entry to document the resident's vital signs every shift and notify the provider of a temperature greater than 100, pulse oxygen saturation less than 90% and heart rate greater than 115.

Review of Resident #1's subsequent primary care provider (PCP) orders and written requests for the facility on 02/17/22 revealed there was no order to discontinue the order to monitor vital signs every shift and notify the provider of a temperature greater than 100, pulse oxygen saturation less than 90% and heart rate greater than 115.

Interview with a medication aide (MA) on 02/17/22 at 2:20pm revealed the MAs documented residents ordered vital signs and pulse oxygen saturation checks on the resident's electronic medication record (eMAR).

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{D 276}	Continued From page 46 Telephone interview with a MA on 02/18/22 at 4:26pm revealed: -She verified her initials were documented as completing Resident #1's oxygen saturations levels on 01/01/22, at 8:00am and 2:00pm, on 01/02/22 at 8:00am and on 01/15/22 at 8:00am. -She could not remember the specific order or the parameter orders for Resident #1's pulse oxygen saturation levels. -She thought she would have rechecked Resident #1's oxygen saturation levels when the reading was below 90% and possibly documented in a 24-hour binder. -The 24-hour binder was used for general documentation for all residents and not part of the residents' record. -She did not contact Resident #1's PCP when oxygen saturations were documented less than 90%. -She could not provide an answer why Resident #1's PCP was not contacted when the resident's oxygen saturations were documented less than 90%. Review of Resident #1's progress notes revealed: -There was no documentation the resident's PCP was notified for oxygen saturations documented less than 90% on 01/01/22 at 8:00am and 2:00pm, 01/02/22 and 01/15/22 at 8:00am. -There was no documentation the resident's vital signs were obtained every shift. Telephone interview with Resident #1's PCP on 02/21/22 at 3:44pm revealed: -She expected for the facility to implement the resident's orders and follow through with all orders provided. -Facility staff had the ability to contact a provider 24 hours a day, if after hours there were on call	{D 276}		

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{D 276}	Continued From page 47 providers. -She would have expected staff to implement and follow through with the order whether it would have been to recheck the resident's pulse oxygen saturation when out of range, and if still out of range obtain a full set of vital signs and if contacted and indicated, a follow-up tele-visit could have been completed with the resident. -When pulse oxygen saturation and vital sign parameters were out of range, and troubleshooting was done by rechecking the results and staff were still obtaining an abnormal reading then she would have expected staff to notify her or the on-call provider within one hour or sooner, dependent on the resident's specific situation. -Resident #1's condition was "chronic in nature" (respiratory limitations) and the PCP thought the resident had episodes of her pulse oxygen saturation levels dipping into the 80's when the resident was up walking or during activity, however, she expected staff to implement the order and notify her as the order was written when pulse oxygen saturation levels were obtained out of parameters in order to treat the resident. -She expected the facility to obtain and document the resident's vital signs as the order was provided. Refer to the interview with the Administrator on 02/18/22 at 5:32pm. Interview with the Administrator on 02/18/22 at 5:32pm revealed: -She expected orders to be implemented and followed up on by the facility within 1-2 days by anyone on the clinical team (the lead medication aide (MA), the Health and Wellness Director (HWD), or the Administrator) at the facility.	{D 276}		

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{D 276}	Continued From page 48 -It was important that orders were implemented and carried out to ensure residents received the care they needed and so the facility could report the results to the PCP for further evaluation. _____ The facility failed to ensure the implementation of orders for vital signs and oxygen saturations with parameters (#1) and for an x-ray, CBC, CMP, and UA/CS for Resident #4 after the diagnosis of COVID-19 to evaluate and treat according based on the resident's status. This failure resulted in a delay in treatment and subsequent 4-day hospitalization with diagnoses to include acute metabolic encephalopathy and pneumonia due to COVID-19. The facility's failure resulted in substantial risk of serious harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/18/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 20, 2022.	{D 276}		
{D 344}	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the	{D 344}		

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forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify medications for 3 of 5 (#1, #2, #4) sampled residents including a medication used to treat anxiety (#2) medications used as a mood stabilizer and a vitamin supplement (#4), and medications used to treat pain and constipation (#1).

The findings are:

1. Review of Resident #2's current FL-2 dated 05/17/21 revealed:
-The resident had diagnoses of coronary artery disease (CAD), chronic systolic congestive heart failure (CHF), hypertensive encephalopathy, and vascular dementia with behavior disturbance.
-He was intermittently disoriented, had wandering behaviors, and was verbally abusive.
-He needed assistance with bathing and dressing.
-He had an indwelling urinary catheter.
-The Special Care Unit was his recommended level of care.

Review of Resident #2's Physician/Healthcare Provider Order Sheet completed by the hospice provider dated 12/13/21 revealed:
-The resident was admitted to hospice with a terminal diagnosis of Cerebral Atherosclerosis. (Cerebral Atherosclerosis is the thickening and hardening of the walls of the arteries in the brain.)
-There was an order written by his hospice provider for Lorazepam 0.5mg every hour as

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needed for anxiety, agitation, or nausea. (Lorazepam is a medication commonly used to treat anxiety.)

Review of Resident #2's records on revealed there was an order written by his primary care provider (PCP) on 12/06/21 for Lorazepam 0.5mg to be administered as one tablet twice a day, one tablet in early afternoon as needed for aggressive behaviors/agitation and one tablet scheduled at bedtime.

Review of Resident #2's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg to be administered at bedtime.
-There was an entry for Lorazepam 0.5mg to be administered every 24-hours as needed for agitation.
-There was an entry for Lorazepam 0.5mg to be administered every 1-hour as needed for anxiety, agitation, or nausea.
-The Lorazepam 0.5mg at bedtime was documented as administered at 8:00pm from 01/01/22-01/31/22.
-The Lorazepam 0.5mg every 24-hours was documented as administered on 01/08/22 at 4:10pm.
-The Lorazepam 0.5mg every 1-hour was documented as administered on 01/09/22 at 12:11am, 01/10/22 at 11:14pm, and 01/21/22 at 5:33pm.

Review of Resident #2's February 2022 eMAR for revealed:
-There was an entry for Lorazepam 0.5mg to be administered at bedtime.
-There was an entry for Lorazepam 0.5mg one tablet to be administered every 1 hour as needed

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for anxiety, agitation, or nausea.
-There was an entry for Lorazepam 0.5mg to be administered every 24 hours as needed for agitation.
-The Lorazepam 0.5mg at bedtime was documented as administered every day at 8:00pm from 02/01/22-02/16/22.
-The Lorazepam 0.5mg every 1-hour was documented as administered on 02/15/22 at 2:44pm.
-The Lorazepam 0.5mg every 24-hour was not documented as administered.

Observation of Resident #2's medications on hand on 02/17/22 at 2:01pm revealed:
-There was a pill pack of Lorazepam 0.5mg filled on 12/13/21 to be administered every 1-hour as needed for anxiety, restlessness, or nausea.
-There were 13 of 20 tablets remaining in the pill pack.
-There was a pill pack of Lorazepam 0.5mg filled on 1/21/22 to be administered every day as needed in the afternoon for aggressive behaviors/agitation.
-There were 30 of 30 tablets remaining in the pill pack.
-There were also 3 pill packs of Lorazepam 0.5mg filled on 01/28/22 to be administered three times a day.
-There were 84 of 84 tablets remaining in the pill pack.

Interview with the Health and Wellness Director (HWD) and Administrator on 02/18/22 at 9:00am revealed:
-They were unaware that Resident #2 had duplicate as needed orders for Lorazepam.
-Medication aides (MA) were expected to ask the HWD, the primary care provider (PCP), or the third-party provider for clarification if there were

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{D 344}	Continued From page 52	{D 344}		

duplicate orders for the same medication.
-It was concerning that Resident #2 had duplicate Lorazepam orders because Lorazepam was a controlled substance that could cause possible over-sedation if doctor's orders were not clarified.

Refer to interview with the lead medication aide (MA) on 02/17/22 at 9:40am.

Refer to interview with the HWD on 02/17/22 at 8:59am.

Refer to interview with the HWD on 02/18/22 at 3:51pm.

Refer to interview with the Administrator on 02/18/22 at 5:32pm.

Refer to interview with the facility's contracted PCP on 02/22/22 at 3:48pm.

2. Review of Resident #4's current FL-2 dated 02/10/22 revealed:
-Diagnoses included dementia, hypertension, peripheral vascular disease, osteoarthritis, and COVID-19.
-There was no documented assessment information.

Review of Resident #4's hospital discharge medications and instructions dated 02/08/22 revealed:
-The orders were electronically signed by the hospital physician.
-There was an order for Seroquel 25mg every 8 hours as needed. (Seroquel is a medication commonly used as a mood stabilizer.)
-There was an order for Zinc 50mg daily for 14 days. (Zinc is used as a vitamin supplement.)

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{D 344}	Continued From page 53 Review of Resident #4's FL-2 dated 02/10/22 revealed: -There was no order for Seroquel 25mg every 8 hours as needed. -There was no order for Zinc 50mg daily for 14 days. Review of Resident #4's mental health provider's orders dated 02/11/22 revealed: -There was no order for Seroquel 25mg every 8 hours as needed. -There was no order for Zinc 50mg daily for 14 days. Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Seroquel 25mg every 8 hours as needed. -The Seroquel 25mg was documented as administered on 02/16/22. -There was an entry for Zinc 50mg once daily for 14 days. -The Zinc 50mg was documented as administered daily from 02/09/22-02/16/22. Telephone interview with Resident #4's mental health provider on 02/18/22 at 2:50pm revealed: -She reviewed and ordered medication changes for the resident after his discharge from the hospital after being medically cleared to address his behaviors on 02/11/22. -She expected the facility to administer the resident's medications as ordered and discontinue medications as ordered to avoid errors. -She expected the facility to call her clarify medication orders if they did not have an order for a medication before administering the medication.	{D 344}		

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{D 344}	Continued From page 54 -She expected the resident's medications to appear on his eMAR accurately to ensure accurate and safe medication administration. Refer to interview with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to interview with the HWD on 02/18/22 at 3:51pm. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted PCP on 02/22/22 at 3:48pm. 3. Review of Resident #1's current FL-2 dated 10/08/21 revealed diagnoses included unspecified atrial fibrillation, unspecified congestive heart failure, type 2 diabetes, restless leg syndrome, pulmonary hypertension, pacemaker, and oxygen dependent. a. Review of Resident #1's current FL-2 dated 10/08/21 revealed there was an order for Tylenol ES 500mg 2 tablets as needed three times a day for pain. (Tylenol is a medication used to treat common aches and pain). Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol ES 500mg 2 tablets as needed three times a day for pain with a scheduled administration time at 8:00am, 2:00pm and 8:00pm. -There was documentation Tylenol ES 500mg 2	{D 344}		

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{D 344}	Continued From page 55	{D 344}		

tablets was administered from 01/01/22 - 01/31/22 at 8:00am, 2:00pm and 8:00pm instead of as needed for pain.
-There was not an entry for Tylenol ES 500mg 2 tablets as needed three times a day for pain.

Review of Resident #1's subsequent medication orders dated 02/10/22 revealed there was an order for Tylenol ES 500mg 2 tablets three times a day for pain.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol ES 500mg 2 tablets as needed three times a day for pain with a scheduled administration time at 8:00am, 2:00pm and 8:00pm.
-There was documentation Tylenol ES 500mg 2 tablets was administered at 8:00am, 2:00pm and 8:00pm from 02/01/22 - 02/10/22 instead of as needed for pain.
-There was not an entry for Tylenol ES 500mg 2 tablets as needed three times a day for pain from 02/01/22 - 02/09/22.

Telephone interview with Resident #1's primary care provider (PCP) on 02/21/22 at 3:44pm revealed:
-Resident #1 was seen by a PCP on 09/15/21 and 10/13/21.
-Resident #1's current medications included Tylenol 500mg 2 capsules three times daily.
-The order for Resident #1's Tylenol 500mg 2 capsules three times daily as needed on the FL-2 dated 10/08/21 should have been clarified since the order was written as needed instead of scheduled.

Refer to interview with the lead medication aide

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{D 344}	Continued From page 56 (MA) on 02/17/22. Refer to interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to interview with the HWD on 02/18/22 at 3:51pm. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted PCP on 02/22/22 at 3:48pm. b. Review of Resident #1's current FL-2 dated 10/08/21 revealed there was an order for MiraLAX packet 17gram daily. (MiraLAX is a medication used to treat constipation). Review of Resident #1's subsequent medication orders dated 02/10/22 revealed there was an order for MiraLAX 17grams every 24 hours as needed for constipation. Review of a previous Resident Concern/Order form for Resident #1 dated 09/15/21 revealed: -The resident did not want to MiraLAX daily and could the order be changed to as needed. -There were new orders to change MiraLAX to as needed once daily. Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for MiraLAX 17gram by mouth every 24 hours as needed for constipation. -There was not an entry for MiraLAX packet 17gram daily. -There was no documentation the resident was administered MiraLAX 17gram daily as ordered	{D 344}		

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{D 344}	Continued From page 57 from 01/01/22 - 01/31/22 Review of Resident #1's February 2022 eMAR revealed: -There was an entry for MiraLAX 17gram by mouth every 24 hours as needed for constipation. -There was not an entry for MiraLAX packet 17gram daily from 02/01/22 - 02/10/22 -There was no documentation the resident was administered MiraLAX 17gram daily as ordered from 02/01/22 -02/09/22. Telephone interview with Resident #1's primary care provider (PCP) on 02/21/22 at 3:44pm revealed the facility would have been responsible to clarify the order for Resident #1's MiraLAX 17gram daily on the FL-2 dated 10/08/22. Refer to interview with the lead medication aide (MA) on 02/17/22. Refer to interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to interview with the HWD on 02/18/22 at 3:51pm. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted PCP on 02/22/22 at 3:48pm. _____ Interview with the lead medication aide (MA) on 02/17/22 at 9:40am revealed: -She was expected to enter medication orders as soon as possible upon receiving them into the resident's electronic medication administration record in the facility's computer system. -Once the order was entered, another MA and the	{D 344}		

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{D 344}	Continued From page 58 Health and Wellness Director (HWD) would review the order for accuracy before the order was made active on the resident's eMAR. -The order was then faxed to the pharmacy so the pharmacy could fill the order, deliver the medication to the facility, and have it on the resident's record. -The facility usually received medications from the pharmacy within one business day of faxing the order to the pharmacy. Interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am revealed: -The lead MA was responsible to enter new medication orders in the facility's computer systems upon receipt. -The order was then double checked by another MA with a final and third check by her for accuracy. -The order was then faxed to the pharmacy for their records and to fill and deliver the medication. -The pharmacy did not enter orders into the facility's computer system or have access to resident's eMARs. -It was the responsibility of the lead MA or the HWD to follow-up or clarify any medication orders as needed. -It was her or the lead MA's responsibility to ensure orders were implemented within one business day. -Medication cart audits were performed weekly by her and the lead MA together. -Cart audits were done to check the accuracy of the medications and ensure they were on hand and available to the resident, as well as, to remove expired medications or medications that were no longer ordered. -She was not aware of any process in place to audit charts and ensure orders were not missed.	{D 344}		

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{D 344}	Continued From page 59 Interview with the HWD on 02/18/22 at 3:51pm revealed: -When a new medication order came in, it was put on a medication tracking form by a MA. -The new medication orders were entered on the eMAR by the MA, checked by the MA on the next shift, and then checked by the HWD. -Chart reviews were done on a monthly basis to check for discontinued orders and to make sure the new orders on the medication tracking form matched what medications were in the medication cart. Interview with the Administrator on 02/18/22 at 5:32pm revealed: -It was the entire clinical team's (the lead MA, the HWD, or the Administrator's) responsibility to ensure orders were accurate and complete. -She expected anyone on the clinical team to clarify medications and orders to ensure accuracy for resident safety. -She expected medications to be administered accurately as ordered and for the eMAR to reflect accurate orders for resident safety. Interview with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm revealed: -She expected the facility to clarify medication orders to accurately match a resident's eMAR for medication administration accuracy and resident safety, especially if more than one provider was prescribing medications for a resident. -Overlapping of medications or inaccurate orders could cause possible medication interactions or overdose. -Therapeutic orders intended by each provider needed to be implemented accurately.	{D 344}		

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{D 358}	Continued From page 60	{D 358}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#6, #7) observed during the medication pass including errors with a medication used as a potassium supplement, an iron supplement, a diuretic for swelling, a medication to treat inflammatory bowel diseases and a medication to treat uncontrollable behaviors of crying and laughing (#6), a supplement to promote gut health and treat diarrhea (#7); and for 1 of 5 residents sampled for record review including an error with a medication used to decrease inflammation after an injury (#2). The findings are: 1. The medication error rate was 22% as evidenced by the observation of 6 errors out of 27 opportunities during the 8:00am medication passes on 02/17/22. a. Review of Resident #6's current FL-2 dated 10/13/21 revealed: -Diagnoses included Alzheimer's disease, vitamin D deficiency, diverticulitis, hyperlipidemia, and	{D 358}		

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{D 358}	Continued From page 61	{D 358}		

hypertension.
-There was an order for Potassium Chloride extended release (ER) 20meq 1 tablet every day. (Potassium Chloride ER is an extended released potassium supplement and should not be crushed. Too much of the medication can be released at one time if it is crushed and it can irritate the mouth and throat.)

Observation of the 8:00am medication pass on 02/17/22 revealed:
-The medication aide (MA) crushed Resident #6's oral tablets and the contents of opened capsules, including the Potassium Chloride ER 20mEq tablet and administered the crushed medications in applesauce at 8:27am.
-The Potassium Chloride was extended released and should not be crushed.

Interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 revealed:
-Resident #6's medications were crushed.
-Resident #6's medications in capsule form were opened and then crushed.
-She thought Resident #6 might have difficulty swallowing some tablets.

Review of Resident #6's February 2022 medication administration record (MAR) revealed:
-There was an entry for Potassium Chloride ER 20meq 1 tablet daily scheduled at 8:00am.
-There was documentation Potassium Chloride ER 20meq was administered at 8:00am on 02/17/22.

Review of Resident #6's Potassium Chloride ER 20meq on hand on 2/28/22 at 2:31pm revealed there was a supply of Potassium Chloride ER 20meq with no labeled instructions not to crush

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{D 358}	Continued From page 62 the medication. A second interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 at 2:20pm revealed: -She was employed at the facility through an outside contracted agency. -She had been working for the facility for about 2 months. -There was not an order in the eMAR system to crush Resident #6's medications. -She was trained by another MA when she first started at the facility to reference a list posted with residents' room numbers located on the medication cart for residents with orders to crush their medications. -The posted list of resident room numbers with orders to crush medications was no longer on the medication cart, she last saw the list last week but unsure of the date. -Resident #6 was on the posted list to crush her medications. -She was now familiar with residents and knew who had a medication crush order. -She was not sure who created or updated the list of residents with orders to crush medications. -She was not aware some of Resident #6's medications could not be crushed because they were in an ER form. -She was not sure if the facility had a do not crush (DNC) medications list, if the facility did have a DNC medication list she had not been informed. -Some of the resident's medication dispensing labels had instructions not to crush, however, Resident #6's Potassium Chloride ER 20meq did not have any specific instructions not to crush. -Another resident was prescribed the same medication (Potassium Chloride ER 20meq) with labeled instructions not to crush the medication.	{D 358}		

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{D 358}	Continued From page 63 Interview with a second MA on 02/17/22 at 9:30am revealed: -Residents' with orders to crush medications were posted on a list on the medication carts. -She thought the "nurse" at the facility updated the list of residents with a medication crush order. Telephone interview with a pharmacist with the facility's contracted provider on 02/18/22 at 11:16am revealed: -Potassium Chloride ER 20meq could not be crushed. -Medications in an ER formula was designed to release a certain amount of the medication over an eight, twelve- or twenty-four-hour period. -When an ER medication was crushed, the level of the medication would not be at a consistent level in the body, causing the effects of the medication to be much shorter because stomach enzymes would begin to breakdown the medication and alter the absorption of the medication. -He was not sure why the dispensing label for Resident #6's Potassium Chloride 20meq did not print to not crush the medication but should have. -The facility staff should have had a Do Not Crush (DNC) list available to reference to when administering medication. -The facility's contracted pharmacy provided a DNC list when pharmacy services were initiated for the facility and DNC lists were available to the facility upon request. Telephone interview with Resident #6's primary care provider (PCP) on 02/21/22 at 3:44pm revealed: -She had "definite" concerns when the MA crushed Resident #6's Potassium Chloride ER because ER medications could not be crushed.	{D 358}		

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{D 358}	Continued From page 64 -If Resident #6 was unable to swallow Potassium Chloride ER, then the resident needed to be placed on a capsule form for the capsule to be opened and administered to the resident. -The resident's Potassium Chloride ER should have been administered without crushing for the medication to act as a time release of the medication and not a "bolus". -She was concerned that crushing Potassium Chloride ER 20meq could have placed the resident at risk for possible heart arrhythmias when administering the medication crushed. -She expected for the facility to have a DNC list available and for the MAs to have common knowledge of not crushing any ER medications. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to the interview with the Administrator on 02/18/22 at 5:32pm. b. Review of Resident #6's current FL-2 dated 10/13/21 revealed there was an order for Budesonide ER 9mg 1 tablet every day. (Budesonide is a medication used to treat inflammatory bowel diseases). Observation of the 8:00am medication pass on 02/17/22 revealed: -The medication aide (MA) crushed Resident #6's oral tablets and the contents of opened capsules, including the Budesonide ER 9mg and	{D 358}		

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{D 358}	Continued From page 65	{D 358}		

administered the crushed medications in applesauce at 8:27am.
-The Budesonide ER 9mg was extended released and should not be crushed.

Interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 revealed:
-Resident #6's medications were crushed.
-Resident #6's mediations that were in capsule form were opened and then crushed.
-She thought Resident #6 might have difficulty swallowing some pills.

Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Budesonide ER 9mg 1 tablet every day with a scheduled administration time at 8:00am.
-There was documentation Budesonide ER 9mg 1 tablet every day was administered on 02/17/22 at 8:00am.

A second interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 at 2:20pm revealed:
-She was employed at the facility through an outside contracted agency.
-She had been working for the facility for about 2 months.
-There was not and order in the eMAR system to crush Resident #6's medications.
-She was trained by another MA when she first started at the facility to reference a list posted with residents' room numbers located on the medication cart for residents with orders to crush their medications.
-The posted list of resident room numbers with orders to crush medications was no longer on the

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BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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medication cart, she last saw the list last week but unsure of the date.
-Resident #6 was on the posted list to crush her medications.
-She was now familiar with residents and knew who had a medication crush order.
-She was not sure who created or updated the list of residents with orders to crush medications.
-She was not aware some of Resident #6's medications could not be crushed because they were in an ER form.
-She was not sure if the facility had a do not crush (DNC) medications list, if the facility did have a DNC medication list she had not been informed.

Telephone interview with a pharmacist with the facility's contracted provider on 02/18/22 at 11:16am revealed:
-Budesonide ER was a do not crush medication.
-When Budesonide was crushed, the medication would not be at a consistent level in the body causing the distribution of the drug to be erratic in the body.
-Stomach enzymes would breakdown the medication faster when crushed.
-The facility staff should have had a Do Not Crush (DNC) list available to reference to when administering medication.
-The facility's contracted pharmacy provided a DNC list when pharmacy services were initiated for the facility and DNC lists were available to the facility on request.

Telephone interview with Resident #1's primary care provider (PCP) on 02/21/22 at 3:44pm revealed she expected for the facility to have a DNC list available and for the MAs to have common knowledge of not crushing any ER medications.

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{D 358}	Continued From page 67 Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to the interview with the Administrator on 02/18/22 at 5:32pm. c. Review of Resident #6's current FL-2 dated 05/05/21 revealed there was an order for Slow Iron 142mg one daily. (Slow Iron is a mineral supplement used to treat fatigue and iron levels in the body). Observation of the 8:00am medication pass on 02/17/22 revealed: -The medication aide (MA) crushed Resident #6's oral tablets, including the Slow Iron 142mg and administered the crushed medications in applesauce at 8:27am. -The Slow Iron 142mg was extended released and should not be crushed. Interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 revealed: -Resident #6's medications were crushed. -Resident #6's mediations that were in capsule form were opened and then crushed. -She thought Resident #6 might have difficulty swallowing some pills. Review of Resident #6's February 2022 electronic medication administration record (eMAR)	{D 358}		

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{D 358}	Continued From page 68 revealed: -There was an entry for Slow Iron extended release 142mg in the morning for low iron, -There was documentation Slow Iron ER 142mg was administered on 02/17/22 at 8:00am. A second interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 at 2:20pm revealed: -She was employed at the facility through an outside contracted agency. -She had been working for the facility for about 2 months. -There was not and order in the eMAR system to crush Resident #6's medications. -She was trained by another MA when she first started at the facility to reference a list posted with residents' room numbers located on the medication cart for residents with orders to crush their medications. -The posted list of resident room numbers with orders to crush medications was no longer on the medication cart, she last saw the list last week but unsure of date. -She was now familiar with residents and knew who was listed with a medication crush order. -She was not sure who created or updated the list of residents with orders to crush medications. -When she prepared Resident #6's medications this morning, she was following the list as she was trained and to crush the residents' medications listed on the list posted on the medication cart. -She was not aware some of Resident #6's medications could not be crushed because they were in an ER form. -She was not sure if the facility had a do not crush (DNC) medications list, if the facility did have a DNC medication list she had not been told.	{D 358}		

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{D 358}	Continued From page 69 Telephone interview with a pharmacist with the facility's contracted provider on 02/18/22 at 11:16am revealed: -Slow Iron ER was a do not crush medication. -When Slow Iron ER was crushed, the medication would not be at a consistent level in the body. -Stomach enzymes would breakdown the medication faster when crushed causing the distribution of the drug to be erratic in the body. -The facility staff should have had a Do Not Crush (DNC) list available to reference to when administering medication. -The facility's contracted pharmacy provided a DNC list when pharmacy services were initiated for the facility and DNC lists were available to the facility on request. Telephone interview with Resident #1's primary care provider (PCP) on 02/21/22 at 3:44pm revealed: -All ER medications should not have been crushed. -The resident could have been at risk for developing gastrointestinal upset when the Slow Iron ER was crushed. -She expected for the facility to have a DNC list available and for the MAs to have common knowledge of not crushing any ER medication. Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am.	{D 358}		

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{D 358}	Continued From page 70 Refer to the interview with the Administrator on 02/18/22 at 5:32pm. d. Review of Resident #6's medication orders revealed there was an order dated 11/11/21 for Furosemide 20mg ½ tablet daily. (Furosemide is a diuretic used to treat swelling and fluid retention.) Observation of the 8:00am medication pass on 02/17/22 revealed: -The medication aide (MA) prepared and administered medications to Resident #6 at 8:27am. -Furosemide was not administered or offered to Resident #6 when she received her other morning medications at 8:27am. Interview with the MA observed during the 8:00am medication pass on 02/17/22 at 8:12am on 02/17/22 at 2:20pm revealed she administered residents' medications by comparing the medications in the eMAR with each medication on hand using the dispensing label on each medication, checking to ensure the right resident, right medication, right dose, right time, and right route. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed there was not an entry for Furosemide 20mg ½ tablet daily. Telephone interview with a pharmacist with the facility's contracted provider on 02/18/22 at 11:16am revealed: -Resident #6 had a current order for Lasix 20mg ½ tablet daily. -Resident #6's Lasix 20 mg ½ tablet was on cycle refills meaning the medication had been	{D 358}		

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automatically sent to the facility monthly since November 2021.
-The facility was not sending Resident #6's monthly batches of Lasix 20 mg ½ tablet back to the pharmacy, there had been no credits or receipts of destruction received.
-Lasix 20mg ½ tablet should have been on Resident #6's eMAR as an active medication.
-Resident #6 would have been at risk for increased fluid build-up if the resident had not been administered the ordered Lasix over an extended time period.

Observation of Resident #6 on 02/18/22 at 5:30pm revealed:
-The resting was sitting in a chair in her with her feet on the floor.
-The resident had compression wraps on both legs from the knee down.
-There was some swelling noted around the top of both wraps just below the knees.

A second interview with the MA observed during the 8:00am medication pass on 02/17/22 at 5:29pm on 02/18/22 revealed:
-Resident #6 did not complain of shortness of breath or leg pain, however, she could tell at times the resident was in pain occasionally.
-Resident #6 had dementia which made it difficult to express when she was experiencing pain.
-Resident #6 had a small "little bit" of swelling at times in her lower legs but she was not aware of her feet being swollen that would have caused her shoes to fit tight.
-Resident #6 had wraps on her lower legs that were applied by a home health nurse each week.

Interview with the Health and Wellness Director on 02/18/22 at 3:15pm revealed:
-She could not provide any additional information

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regarding Resident #6's Lasix order.
-She was not aware Resident #6 was not receiving Lasix as ordered.
-She expected all medications to be administered as ordered.

Telephone interview with Resident #6's primary care provider (PCP) on 02/21/22 at 3:44pm revealed:
-Resident #6 had a current order for Lasix 20mg 1/2 tablet daily as of 02/10/22.
-Resident #6 could develop fluid overload and exacerbation of congestive heart failure if Lasix was not administered to the resident as ordered.
-Her last visit with the resident was on 02/10/22 and she did not note any increased fluid, however if the resident was not receiving Lasix, the resident could have developed fluid build-up easily since 02/10/22.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am.

Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am.

Refer to the interview with the Administrator on 02/18/22 at 5:32pm.

e. Review of Resident #6's medication orders revealed there was an order for Nuedexta 20-10mg, one daily in the morning dated 10/13/21. (Nuedexta is a medication used to treat involuntary, sudden, and frequent episodes of crying and frequent episodes with certain neurologic conditions or brain injury).

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{D 358}	Continued From page 73 Observation of the 8:00am medication pass on 02/17/22 revealed: -The medication aide (MA) prepared and administered medications to Resident #6 at 8:27am. -Nuedexta 20-10mg was not administered or offered to Resident #6 when she received her other morning medications at 8:27am. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed there was no entry for Nuedexta 20-10mg, one daily in the morning. Interview with the MA observed during the medication pass on 02/17/22 at 8:12am on 02/17/22 at 2:20pm revealed she administered the resident's medications by comparing the medications in the eMAR to each medication on hand using the dispensing label on each medication, checking to ensure the right resident, right medication, right dose, right time, and right route . Telephone interview with a pharmacist with the facility's contracted provider on 02/18/22 at 11:16am revealed: -There was no discontinued order for Resident #6's Nuedexta 9mg daily. -Nuedexta was on cycle refills meaning the medication had been automatically sent to the facility monthly since November 2021. -The facility was not sending Resident #6's Nuedexta 9mg medication back to the pharmacy, there had been no credits or receipts of destruction received. -If Resident #6 was not receiving Nuedexta 9mg, the resident could experience uncontrolled behaviors.	{D 358}		

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{D 358}	Continued From page 74 Interview with the Health and Wellness Director on 02/18/22 at 3:15pm revealed: -She could not provide any additional information regarding Resident #6's Nuedexta order. -She was not aware Resident #6 was not receiving Nuedexta as ordered. -She expected all medications to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to the interview with the Administrator on 02/18/22 at 5:32pm. f. Review of Resident #7's current FL-2 dated 01/12/22 revealed: -Diagnoses included unspecified hypertension, edema, respiratory failure, urinary tract infection, fibromyalgia, other idiopathic peripheral autonomic neuropathy, and general muscle weakness. -There was an order for a Probiotic one daily. (Probiotics is a supplements that aid in digestion and immune support). Observation of the 8:00am medication pass on 02/17/22 revealed: -The medication aide (MA) prepared and administered medications to Resident #7 at 8:27am. -A Probiotic was not administered or offered to	{D 358}		

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Resident #6 when she received her other morning medications at 9:06am.

Review of Resident #7's February 2022 electronic medication administration record (eMAR) revealed there was no entry for a Probiotic one daily.

Interview with the MA observed during the medication pass on 02/17/22 at 8:27am on 02/17/22 at 11:37am and at 3:05pm revealed:
-She administered the resident's medications by comparing the medications in the eMAR the to the medications on hand.
-If a medication was not on the resident's eMAR, the MA would not administer the medication.

Telephone interview with a pharmacist with the facility's contracted provider on 02/18/22 at 11:16am revealed:
-Resident #7 had a current order for Probiotic 250mg daily.
-Resident #7's Probiotic was delivered every month by cycle fill and had not been returned to the pharmacy for nonuse.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am.

Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am.

Refer to the interview with the Administrator on 02/18/22 at 5:32pm.

2. Review of Resident #2's current FL-2 dated

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{D 358}	Continued From page 76 05/17/21 revealed: -The resident had diagnoses of coronary artery disease (CAD), chronic systolic congestive heart failure (CHF), hypertensive encephalopathy, and vascular dementia with behavior disturbance. -The Special Care Unit was his recommended level of care. Review of Resident #2's emergency department (ED) after visit summary on 01/08/22 revealed the resident was seen for foot pain and diagnosed with an ankle sprain. Review of a physician's order for Resident #2 revealed there was an order dated 01/15/22 for Methylprednisolone 4mg dose pack to be given daily and tapered over 6 days. (Methylprednisolone is a medication used to decrease inflammation.) Review of a pharmacy prescription receipt for Resident #2 dated 01/15/22 revealed that a prescription had been filled for Methylprednisolone 4mg to be given daily as directed on the packaging. Review of Resident #2's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Methylprednisolone 4mg to be administered every 8 hours as needed for pain and inflammation for 6 days (01/15/22-01/21/22). -The Methylprednisolone was not administered. Interview with a pharmacist from the facility's contracted pharmacy provider on 02/18/22 at 3:18pm revealed: -Resident #2's Methylprednisolone was filled by the facility's back-up pharmacy on 01/15/22.	{D 358}		

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{D 358}	Continued From page 77 -The Methylprednisolone was ordered to be given as directed on the dose pack. -The directions on a Methylprednisolone 4mg dose pack were: Day 1: Give two tablets before breakfast, one tablet after lunch, one tablet after supper, and two tablets at bedtime Day 2: Give one tablet before breakfast, one tablet after lunch, one tablet after supper, and two tablets at bedtime. Day 3: Give one tablet before breakfast, one tablet after lunch, one tablet after supper, and one tablet at bedtime. Day 4: Give one tablet before breakfast, one tablet after lunch, and one tablet at bedtime. Day 5: Give one tablet before breakfast and one tablet at bedtime. Day 6: Give one tablet before breakfast. Interview with the HWD on 02/18/22 at 3:51pm revealed: -When a new medication order came in it was put on a medication tracking form by a MA. -The new medication orders were entered on the eMAR by the MA, checked by the MA on the next shift, and then checked by the HWD. -Chart reviews were done on a monthly basis to check for discontinued orders and to make sure the new orders on the medication tracking form matched what medications were in the medication cart. -She was not aware that Resident #2 did not receive his Methylprednisolone as ordered. -She was not aware that the Methylprednisolone had been put on the eMAR to be administered as needed instead of as ordered per the dose pack. -Methylprednisolone was usually administered as a loading dose and then decreased over time. -It was a concern that the resident did not receive the Methylprednisolone as ordered because it	{D 358}		

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{D 358}	Continued From page 78 was ordered for a specific reason. Interview with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm revealed: -She expected the facility to ensure medication orders were accurate and matched the orders to a resident's eMAR for medication administration accuracy and resident safety, especially if more than one provider was prescribing medications for a resident. -Overlapping of medications or inaccurate orders could cause possible medication interactions or overdose and therapeutic orders intended by each provider needed to be implemented accurately. Refer to the interview with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to the interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to the interview with the Administrator on 02/18/22 at 5:32pm. _____ Interview with the lead medication aide (MA) on 02/17/22 at 9:40am revealed: -She was expected to enter medication orders as soon as possible upon receiving them onto the resident's eMAR in the facility's computer system. -Once the order was entered, another MA and the Health and Wellness Director (HWD) would review the order for accuracy before the order was made active on the resident's eMAR for administration. -The order was then faxed to the pharmacy so the pharmacy could fill the order, deliver the medication to the facility, and have it on the resident's profile.	{D 358}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 79 -The facility usually received medications from the pharmacy within one business day of faxing the order to the pharmacy. Interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am revealed: -The lead MA was responsible to enter new medication orders in the facility's computer systems upon receipt. -The order was then double checked by another MA with a final and third check by her for accuracy. -The order was then faxed to the pharmacy for their records and to fill and deliver the medication. -The pharmacy did not enter orders into the computer systems or have access to resident's eMAR. -It was the responsibility of the lead MA or the HWD to follow-up or clarify any medication orders as needed. -It was her or the lead MA's responsibility to ensure orders were implemented within one business day. -Medication cart audits were performed weekly by her and the lead MA together. -Cart audits were done to check the accuracy of the medications and ensure they were on hand and available to the resident as well as to removed expired medications or medications that were no longer ordered. -She was not aware of any process in place to audit charts and ensure orders were not missed. Interview with the Administrator on 02/18/22 at 5:32pm revealed: -It was the entire clinical team's responsibility to ensure orders were accurate and complete. -She expected anyone on the clinical team (the lead MA, the HWD, or the Administrator) to clarify medications and orders to ensure accuracy for	{D 358}		

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{D 358}	Continued From page 80 resident safety. -She expected medications to be administered accurately as ordered and for the eMAR to reflect accurate orders for resident safety.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure accuracy of electronic medication administration records (eMARs) for 2 of 5 sampled residents to include a steroid medication (#2) and a vitamin supplement (#4). The findings are:	{D 367}		

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{D 367}	Continued From page 81 1. Review of Resident #2's current FL-2 dated 05/17/21 revealed the resident had diagnoses of coronary artery disease, chronic systolic congestive heart failure, hypertensive encephalopathy, and vascular dementia with behavior disturbance. Review of a physician's order for Resident #2 revealed there was an order dated 01/15/22 for Methylprednisolone 4mg dose pack to be given daily and tapered over 6 days. (Methylprednisolone is a medication used to decrease inflammation.) Review of a pharmacy prescription receipt for Resident #2 dated 01/15/22 revealed that a prescription had been filled for Methylprednisolone 4mg to be given daily as directed on the packaging. Review of Resident #2's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Methylprednisolone 4mg to be administered very 8 hours as needed for pain and inflammation for 6 days (01/15/22-01/21/22). -The Methylprednisolone was not administered. Interview with the facility's contracted pharmacist on 02/18/22 at 3:18pm revealed: -Resident #2's Methylprednisolone was filled by the facility's emergency pharmacy on 01/15/22. -The Methylprednisolone was ordered to be given as directed on the dose pack. -The directions on a Methylprednisolone 4mg dose pack were: Day 1: Give two tablets before breakfast, one tablet after lunch, one tablet after supper, and two	{D 367}		

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{D 367}	Continued From page 82	{D 367}		

tablets at bedtime
Day 2: Give one tablet before breakfast, one tablet after lunch, one tablet after supper, and two tablets at bedtime.
Day 3: Give one tablet before breakfast, one tablet after lunch, one tablet after supper, and one tablet at bedtime.
Day 4: Give one tablet before breakfast, one tablet after lunch, and one tablet at bedtime.
Day 5: Give one tablet before breakfast and one tablet at bedtime.
Day 6: Give one tablet before breakfast.

Refer to interview with the lead medication aide (MA) on 02/17/22 at 9:40am.

Refer to interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am.

Refer to interview with the Administrator on 02/18/22 at 5:32pm.

Refer to interview with the facility's contracted PCP on 02/22/22 at 3:48pm.

2. . Review of Resident #4's current FL-2 dated 02/10/22 revealed diagnoses included dementia, hypertension, peripheral vascular disease, osteoarthritis, and COVID-19.

Review of Resident #4's hospital discharge medications and instructions dated 02/08/22 revealed:
-The orders were electronically signed by the hospital physician.
-There was an order for Vitamin C 500mg daily for 14 days. (Vitamin C is a vitamin supplement commonly used to boost the immune system.)

Review of Resident #4's FL-2 dated 02/10/22

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{D 367}	Continued From page 83 revealed there was an ongoing order for Vitamin C 500mg daily beyond 14 days. Review of Resident #4's February electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin C 500mg daily for 14 days. -There was no entry for Vitamin C 500mg daily beyond 14 days. Refer to interviews with the lead medication aide (MA) on 02/17/22 at 9:40am. Refer to interview with the Health and Wellness Director (HWD) on 02/17/22 at 8:59am. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted PCP on 02/22/22 at 3:48pm. _____ Interview with the lead medication aide (MA) on 02/17/22 at 9:40am revealed: -She was expected to enter medication orders as soon as possible upon receiving them into the resident's eMAR in the facility's computer system. -Once the order was entered, another MA and the Health and Wellness Director (HWD) would review the order for accuracy before the order was made active on the resident's eMAR. Interview with the HWD on 02/17/22 at 8:59am revealed: -The lead MA was responsible to enter new medication orders in the facility's computer systems upon receipt. -The order was then double checked by another MA with a final and third check by her for	{D 367}		

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{D 367}	Continued From page 84	{D 367}		

accuracy.
-Medication cart audits were performed weekly by her and the lead MA together.
-Cart audits were done to check the accuracy of the medications as compared to the eMARs and ensure they were on hand and available to the resident as well as to removed expired medications or medications that were no longer ordered.
-She was not aware of any process in place to record charts and ensure orders were not missed.

Interview with the Administrator on 02/18/22 at 5:32pm revealed:
-It was the entire clinical team's (the lead MA, the HWD, or the Administrator's) responsibility to ensure orders were accurate and complete.
-She expected anyone on the clinical team to clarify medications and orders to ensure accuracy for resident safety.
-She expected medications to be administered accurately as ordered and for the eMAR to reflect accurate orders for resident safety.

Interview with the facility's contracted PCP on 02/22/22 at 3:48pm revealed:
-She expected the facility to ensure medication orders were accurately and match the orders to a resident's eMAR for medication administration accuracy and resident safety, especially if more than one provider was prescribing medications for a resident.
-Overlapping of medications or inaccurate orders could cause possible medication interactions or overdose and therapeutic orders intended by each provider needed to be implemented accurately.

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{D 468}	Continued From page 85	{D 468}		
{D 468}	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that 3 of 3 sampled staff (Staff A, B, and E) completed 6 hours of orientation for the specific nature and needs of the Special Care Unit (SCU) within the first week	{D 468}		

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{D 468}	Continued From page 86 of hire. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired on 12/01/21. -She worked on the Special Care Unit (SCU). -There was documentation of 4.75 out of 6 hours of training on the specific nature and needs of SCU residents completed by 12/03/21. Refer to interview with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm. 2. Review of Staff B's personnel record revealed: -Her documented hire date was 12/26/21. -She was a personal care aide (PCA) on the SCU. -Staff B had 5.25 documented hours of training on the specific nature and needs of SCU residents completed since 02/17/21. Interview with Staff B on 02/16/22 at 12:11pm revealed she had been employed at the facility since January 2021, not December 2021. Refer to interview with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted	{D 468}		

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{D 468}	Continued From page 87 primary care provider (PCP) on 02/22/22 at 3:48pm. 3. Review of Staff E's personnel record revealed: -She was hired on 09/20/21. -She worked on the Special Care Unit (SCU). -There was no documentation of 6 hours of orientation on the specific nature and needs of SCU residents. Refer to interview with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interview with the Administrator on 02/18/22 at 5:32pm. Refer to interview with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm. _____ Interview with the BOM on 02/18/22 at 6:05pm revealed: -She was responsible for ensuring staff received their proper training and maintaining the documentation to show staff's training. -She knew staff did not have enough hours in SCU specific training and had brought it to the Administrator's attention a few months ago. -The SCU training for staff was short because it was hard to find online training and in-person training had stopped due to the COVID-19 outbreak. -When she made the Administrator aware that the SCU specific training was short, she was told to proceed, start over at the beginning of 2022, and try to get the staff caught up. Interview with the Administrator on 02/18/22 at 5:32pm revealed: -The Business Office Manager (BOM) was	{D 468}		

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{D 468}	Continued From page 88 responsible to ensure staff training was accurate and complete. -She was not aware that staff were short on SCU specific training and the requirements should have been met. Interview with the facility's contracted PCP on 02/22/22 at 3:48pm revealed: -She expected MAs to have the appropriate and required training to ensure proper and safe care of the residents in the SCU. -It was important for staff to have SCU specific training with follow-up education to staff could safely respond is issues such as safety, hazards, reaction to behaviors, and therapeutic responses to residents with dementia.	{D 468}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, personal care and supervision, and housekeeping and furnishings. The findings are: 1. Based on observations, interviews, and record	{D912}		

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{D912}	Continued From page 89 reviews the facility failed to ensure the safe storage of oxygen tanks on the Assisted Living Unit (AL) and failed to ensure the facility was free of hazards left accessible to 11 residents on the Special Care Unit (SCU). [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on record review and interviews, the facility failed to notify the primary care provider for 2 of 5 sampled residents (#5, #3) related to rectal bleeding (#5) and two falls within one week of admission (#3). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to provide supervision to 1 of 5 sampled residents (#3) who had a history of falls prior to admission and two falls within a one-week period of admission. [Refer to Tag 270, 10A NCAC 13F .0901(b) Supervision (Type B Violation)].	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations	D914		

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D914	Continued From page 90 as related to health care. The findings are: Based on interviews, and record reviews, the facility failed to ensure implementation of physician's orders for 2 of 5 sampled residents (#4, #1) regarding orders for an x-ray and labs (#4) and an order for vitals signs and oxygen saturations each shift with parameters (#1).[Refer to tag 276, 10A NCAC 13F .0902(c)(3-4)(Type A2 Violation)]	D914		
{D935}	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A	{D935}		

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{D935}	Continued From page 91 NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 5 sampled staff (A, D, E, and F) who administered medications completed the 5, 10, or 15-hour medication administration training course or had documentation of a medication aide clinical skills evaluation (D and F). The findings are: 1. Review of Staff D's personnel record revealed: -She had a hire date of 03/15/19 and had the title of a medication aide (MA). -She passed the Medication Administration exam on 11/13/12. -She was signed off on the Medication Clinical Skills on 03/22/19. -There was no documentation of Staff D completing the 5,10, or 15-hour Medication Administration Training Course. -There was not a MA Employment Verification	{D935}		

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{D935}	Continued From page 92 form for Staff D. Refer to interviews with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interviews with the Administrator on 02/18/22 at 5:32pm. Refer to interviews with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm. 2. Review of Staff F's personnel record revealed: -She had a hire date of 07/16/21 and had the title of a medication aide (MA). -She passed the Medication Administration exam on 04/20/17. -She was not signed off on the Medication Clinical Skills. -There was no documentation of Staff F completing the 5, 10 or 15-hour Medication Administration Training Course. Refer to interviews with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interviews with the Administrator on 02/18/22 at 5:32pm. Refer to interviews with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm. 3. Review of Staff A's personnel record revealed: -She had a hire date of 12/01/21 and had the title of a medication aide (MA). -She passed the Medication Administration exam on 12/09/02. -She was signed off on the Medication Clinical Skills on 12/20/21.	{D935}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D935}	Continued From page 93 -There was no documentation of Staff A completing the 5, 10 or 15-hour Medication Administration Training Course. Refer to interviews with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interviews with the Administrator on 02/18/22 at 5:32pm. Refer to interviews with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm. 4. Review of Staff E's personnel record revealed: -She had a hire date of 09/20/21 and had the title of a medication aide (MA). -She passed the Medication Administration exam on 05/07/08. -She was signed off on the Medication Clinical Skills on 03/22/19. -There was no documentation of Staff E completing the 5, 10 or 15-hour Medication Administration Training Course. Refer to interviews with the Business Office Manager (BOM) on 02/18/22 at 6:05pm. Refer to interviews with the Administrator on 02/18/22 at 5:32pm. Refer to interviews with the facility's contracted primary care provider (PCP) on 02/22/22 at 3:48pm. _____ Interview with the Business Office Manager (BOM) on 02/18/22 at 6:05pm revealed: -She was responsible for ensuring staff received their proper training and maintaining the documentation to show staff's training.	{D935}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D935}	Continued From page 94 -She was not aware that medication aides (MAs) who started before 2013 were grandfathered to the rules but still needed refresher training every two years. -She had only been in her role for two years and was still learning all the rules. -The lack of accurate training for MAs at the facility was an oversight on her part and she was trying to get everyone caught up. Interview with the Administrator on 02/18/22 at 5:32pm revealed: -The BOM was responsible to ensure staff training was accurate and complete. -She was not sure if the MAs had the appropriate training on file. Interview with the facility's contracted primary care primary care provider (PCP) on 02/22/22 at 3:48pm revealed she expected MAs to have the appropriate and required training to ensure proper and safe mediation administration to the resident's in the facility.	{D935}		